PRINTED: 08/26/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVN3873AGC 08/18/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1453 PASS DRIVE CENTER FOR HOPE OF THE SIERRAS LLC **RENO, NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Y 000 Initial Comments Y 000 This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted in your facility on 8/18/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for persons with a mental illness, Category I residents. The census at the time of the survey was four. Four resident files were reviewed and ten employee files were reviewed. One discharge file was reviewed. Y 103 449.200(1)(d) Personnel File - NAC 441A Y 103 SS=F NAC 449,200 1. Except as otherwise provided in subsection 2. a separate personnel file must be kept for each See Copies of Physician Statement & member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected RECEIVED cases; surveillance and testing of employees; counseling and preventive treatment. SEP 09 2008 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical BUREAU OF LICENSURE facility or a facility for the dependent must be AND CERTIFICATION CARSON CITY, NEVADA managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Exec. DIRECTOR/CHS If continuation sheet 1 of 12

	Time.
1	
	- 1
1	

	-)	
-	-/	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CO	INSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVN3873AGC

B. WING

08/18/2008

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

ENTER	FOR HOPE OF THE SIERRAS LLC	1453 PAS RENO, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
Y 103	Continued From page 1		Y 103		
Y 103	2. A medical facility, a facility for the deperation of the individual residential care shat maintain surveillance of employees of the or home for tuberculosis and tuberculosis infection. The surveillance of employees conducted in accordance with the recommendations of the Centers for Disection and Prevention for preventing the transmission of tuberculosis in facilities phealth care set forth in the guidelines of the Centers for Disease Control and Prevential adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person entitial amedical facility, a facility for the deperation and entitial employment, a person in a medical facility, a facility for the deperation of the individual residential care shat a: (a) Physical examination or certification for licensed physician that the person is in a good health, is free from active tuberculous any other communicable disease in a constage; and (b) Tuberculosis screening test within the preceding 12 months, including persons in history of bacillus Calmette-Guerin (BCG vaccination). If the employee has only completed the form a 2-step Mantoux tuberculin skin test or other step of the second structure of the facility designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of test documents that determination. The risk of comments that determination. The risk of comments that determination.	e facility s must be ease e coroviding the tion as enployed endent or all have from a state of posis and intagious with a interport the tep of the her nust be is reafter, or his ing and of	Y 103		
	exposure and corresponding frequency of examination must be determined by follows:				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

RECEIVE In Continuation sheet 2 of 12



FORM APPROVED

	OF CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N	IUMBER:	(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION 3	COMPL	
	PROVIDER OR SUPPLIER	<u> </u>		S DRIVE	TATE, ZIP CODE		10/2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Y 103	Prevention as ado (h) of subsection 14. An employee wipositive tuberculos from screening wit radiographs unless suggestive of tube 5. A person who distuberculosis screet to subsection 3 shand medical evaluation 6. Counseling and offered to a person screening test in a of the Centers for Prevention as ado (g) of subsection 17. A medical facilitiemployees for the symptoms. A person a positive tuber report promptly to if any, or to the direct of the medical facilities of the medical facilities any pulmonary syrof tuberculosis are be evaluated for tuberculosis (TB). Findings include: Employee #6 - Hinemployee's file control of the medical facilities are possible for the medical facilities of tuberculosis (TB).	centers for Disease pted by reference in of NAC 441A.200. Ith a documented his is screening test is the skin tests or chests have developed symperculosis. It is a developed symperculosis of the screening test administer all submit to a chest ation for active tube preventive treatment with a positive tube preventive treatment with a positive tube occordance with the Disease Control and pted by reference in of NAC 441A.200. It is shall maintain sundevelopment of pullion with a history of culosis screening test the infection control ector or other personality if the medical factor of control special in the present, the employed in the employed in the employed in the present, the employed in the screening test in the employed in the employed in the employed in the employed in the present, the employed in the present, the employed in the present in the p	story of a exempt toms ive ed pursuant tradiograph reulosis. In the erculosis guidelines of paragraph veillance of monary tuberculosis st shall specialist, in charge cility has not list, when symptoms yee shall the facility of the ning.	V 103			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

RECEIVED continuation sheet 3 of 12

FORM APPROVED

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NVN3873AGC 08/18/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1453 PASS DRIVE CENTER FOR HOPE OF THE SIERRAS LLC **RENO, NV 89509** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Y 103 Y 103 Continued From page 3 contained another one-step TB skin test read on 2/29/08. For the employee to comply with NAC 441A.375, the employee needs an additional one-step TB skin test. This test can be combined with the 2/29/08 test to qualify as a two-step TB skin test. The file did not contain a physical examination or a statement from a physician that the employee was in a state of good health, was free from active TB and any other disease in a contagious stage. Employee #7 - Hire date was 10/22/07. The employee file did not contain a physical examination or a statement from a physician that the employee was in a state of good health, was free from active TB and any other disease in a contagious stage. Employee #8 - Hire date was 9/3/07. The employee file did not contain a physical examination or a statement from a physician that the employee was in a state of good health, was free from active TB and any other disease in a contagious stage. This was a repeat deficiency from the 8/29/07 annual State Licensure survey. Y 171 See copie of RENO Bus. lic. Severity: 2 Scope: 3 Y 171 449.209(1)(b) Health and Sanitation-Local Laws Y 171 SS=C NAC 449,209 1. A residential facility must: (b) Comply with all local ordinances and state and

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

federal laws and regulations relating to zoning, sanitation, accessibility to persons with disabiltiles

STATE FORM

4JJD11

RECEIVE Continuation sheet 4 of 12



C

PRINTE FORI

Bureau o	of Licensure and Ce	ertification					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N	UMBER:	(X2) MULTI A. BUILDIN B. WING _	•	(X3) DATE S COMPLE	
NAME OF P	ROVIDER OR SUPPLIER	1 11110070700		DRESS, CITY, S	STATE, ZIP CODE	00/1	0/2000
CENTER	FOR HOPE OF THE	SIERRAS LLC	1453 PAS RENO, NV				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE RE APPROPRIATE	(X5) COMPLETE DATE
Y 171	Continued From pa	age 4		Y 171			
	and safety.						
	Based on observation failed to maintain a Findings include: A business license office located over license was issued	not met as evidence tion on 8/18/08, the is a current business lice was posted in the but the garage. The but by the City of Reno	facility cense. pusiness isiness and had	0/2			
:	with local zoning re	to determine if the fa egulations was not p			y 920 See Copy to to define M Storage pra		
	Severity: 1 Scope	e: 3				y PAP	
Y 920 \$S=C	449.2748(1) Medic	cation Storage		Y 920	to define M	edication	ļ.
	over-the-counter m stored at a resident facility must be sto area that is cool ar caregivers employ shall ensure that a	itial ired in a locked nd dry. The ed by the facility	ion, any		Storage pra	c71 C.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself

STATE FORM

4JJD11

If continuation sheet 5 of 12



Bureau of Licensure and Cer	rtification		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN3873AGC	B. WING	08/18/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	S ID	PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
Y 920	Continued From page 5 without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.	Y 920	
in the second se	This Regulation is not met as evidenced Based on observation on 8/18/08, the fat failed to store external medications separated from oral medications for 1 of 1 resident Findings include: Resident #4's medications were inspect tubes of Analpram were observed being with three oral medication bottles. One tubes of Analpram had been opened and Severity: 1 Scope: 3	cility arately s. ed. Two stored of the	V936 and V940
Y 936 SS=F	A49.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for resident of a residential facility and retain least 5 years after he permanently leave facility. The file must be kept locked in a that is resistant to fire and is protected a unauthorized use. The file must contain records, letters, assessments, medical information and any other information rethe resident, including without limitation: (e) Evidence of compliance with the prochapter 441A of NRS and the regulation adopted pursuant thereto.	ned for at a street a place gainst all	y936 and y940 See copy of new P&P for Residents who are in treatment for 1 year from their Admission date

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

RECEIVED Sheet 6 of 12

Bureau of Licensure and Cer	rtification			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN3873AGC		B. WING	08/18/2008
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	
CENTER FOR HOPE OF THE SIERRAS LLC		1453 PASS		

SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 936 Y 936 Continued From page 6 This Regulation is not met as evidenced by: NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM 4JJD11



If continuation sheet 7 of 12

Bureau of Licensure and Ce	rtification	
STATEMENT OF DESIGNATION		

	NVN3873AGC	B. WING	08/18/2008
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CENTER	FOR HOPE OF THE SIERRAS LLC	1453 PAS RENO, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Y 936 Continued From page 7		Y 936		
Y 936	Continued From page 7 person arrives at the facility or home or days after the patient is admitted, which sooner. (c) If the person has only completed the of a two-step Mantoux tuberculin skin tet the 12 months preceding admission, ent the person has a second two-step Mantous tuberculin skin test or other single-step tuberculosis screening test. After a person had an initial tuberculosis screening test facility or home shall ensure that the person a single tuberculosis screening test annuthereafter, unless the medical director of designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of test documents that determination. The risk exposure and corresponding frequency examination must be determined by folking guidelines as adopted by reference in person skin testing and routine annual cheradiographs, but the staff of the facility of shall ensure that the person is evaluated annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home dete that a person has had a cough for more weeks and that he has one or more of the symptoms described in paragraph (a) or subsection 2, the person may be admitted facility or home if the staff keeps the per respiratory isolation in accordance with guidelines of the Centers for Disease Correvention as adopted by reference in person the content of the person of the content of the content of the person of the content of the content of the person of the content of the content of the person of the content of the content of the content of the person of the content of the con	first step st within sure that oux on has t, the rson has ually r his sting and of of owing the aragraph of a kempt est or home d at least rmines than 3 he other f ed to the rson in the ontrol and paragraph stil a	Y 936		
	person has active tuberculosis. If the sta	:			
C 1 - C	e are cited, an approved plan of correction must be		40		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

If continuation sheet 8 of 12



Bureau	of Licensure and Cer	rtification				FORM.	APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	FOR HOPE OF THE	SIERRAS LLC	1453 PAS RENO, NV	S DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
Y 936	Continued From pa	ige 8		Y 936			
	the staff shall not a care provider deternot have active tubes. If a test or evaluation has suspected or a the facility or home the facility or home admitted, shall not the facility or home keeps the person in person must be kell health care provided does not have actival though the person to longer infectious not certify that a penot infectious unless obtained not less the sputum AFIB smease parate days. 6. If a test indicates or will be admitted tuberculosis, the stensure that the per in accordance with	erson in respiratory is dmit the person until mines that the person erculosis. Attion indicates that a ctive tuberculosis, the shall not admit the port, if he has already allow the person to require the person to respiratory isolation of in respiratory isolation of the respiratory isolation of the tuberculosis or central has active tuberculosis. A health care proving the health care proving the province of the health care proving the province that a person who has a facility or home is that a person who has a facility or home is the recommendation of the facility or home is treated for the the recommendation of the control and Preventation in the province of the control and Preventation in the person who has affected for the commendation of the control and Preventation in the person who has affected for the control and Preventation in the person who has a facility or home in the person	a health in does person to been emain in rhome in The tion until a person rtifies that, osis, he is ider shall erculosis is ovider has e negative ited on has active ome shall e disease is of the				

that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in

paragraph (h) of subsection 1 of NAC 441A.200.

7. The staff of the facility or home shall ensure

the counseling of, and effective treatment for, a

recommendations are set forth in the guidelines

Prevention as adopted by reference in paragraph

person having active tuberculosis. The

of the Centers for Disease Control and

(g) of subsection 1 of NAC 441A.200.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

If continuation sheet 9 of 12



		FO
DER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	
		NVN3873AGC		B. WING		08/1	8/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
CENTER	FOR HOPE OF THE	SIERRAS LLC	1453 PAS RENO, NV				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Y 936	that any action carrand the results ther person 's medical (Added to NAC by 3-28-96; R084-06, Based on record redid not ensure that the required tuberous Findings include: Resident #4- Date resident sfile contaresident completed testing on 8/3/07. The resident received test by 8/3/08. This was a repeat of	acility or home shall ried out pursuant to the reof are documented record. Bd. of Health, eff. 1-27-14-2006) Eview on 8/18/08, the 1 of 4 residents had rulosis (TB) skin testing of admission 7/23/07 sined documentation the required two-step an annual one-step deficiency from the 7 I State Licensure sur	facility received ng. 7. The the p TB skin in proof p TB skin /25/06	Y 936			
Y 940 SS=C	449.2749(1)(g)(3) I	Resident file		Y 940			
	resident of a reside least 5 years after facility. The file mu that is resistant to f unauthorized use.	nust be maintained for the permanently leave ust be kept locked in fire and is protected and the file must contain sessments, medical	ined for at es the a place against				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

information and any other information related to the resident, including without limitation: (g) An evaluation of the resident's ability to

STATE FORM 6899 4JJD11 If continuation sheet 10 of 12



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVN3873AGC

B. WING

08/18/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF F	ROVIDER OR SUPPLIER	OTTLE I ADE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	STATE, ZIF CODE	
CENTER	FOR HOPE OF THE SIERRAS LLC	1453 PASS RENO, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 940	Continued From page 10 perform the activities of daily living and a description of any assistance he needs to perform those activities. The facility shall such an evaluation: (3) In any event, not less than once expear.	o Il prepare	Y 940		
	This Regulation is not met as evidenced Based on record review on 8/18/08, the fidd not perform an annual evaluation of a resident's ability to perform the activities living on 1 of 1 residents residing in the fidonger than a year.	facility a of daily			
	Findings include:				
ļ	Resident #4 - Date of admission was 7/2 The resident's file did not contain an ann evaluation of the resident's ability to perfe activities of daily living for July of 2008.	ual			
	Severity: 1 Scope: 3			y9999	
Y9999	Final Observations NAC 449.0114 Display of license; compl with law; transfer of real property; change administrator, ownership, location or sen (NRS 449.037, NRS 449.050) 1. Upon receipt of a license, the licensee	e in vices. e shall	Y9999	See copy of House (1453 Pass DR.) Bus lic & STATE CIC. disp in Public view.	e / iness played
	display the license at a conspicuous loca within the facility. NAC 654.190 Display of license. (NRS 6 Each person licensed as a nursing facility administrator or an administrator of a restacility for groups shall conspicuously displayed.)	54.110) y sidential	OKA		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

4JJD11

RECEIVE Continuation sheet 11 of 12

buleau of Licensule and Cer	uncation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN3873AGC		B. WING	08/18/2008
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
CENTER	FOR HOPE OF THE SIERRAS LLC	1453 PAS RENO, N					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y9999	Continued From page 11 original license in a public place within of which he is the administrator of reconstruction on 8/18/08, the failed to post its administrator's license bureau license in a conspicuous place facility. Findings include: During a facility tour, the administrator and bureau license were not posted in conspicuous place within the facility for and visitors to see. These two license posted in a second story business officioner the garage.	facility e and their within the 's license a r residents s were	Y9999				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

199

4JJD11

RECEI Continuend is neet 12 of 12
SEP 0 9 2008

